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THE SURGEON'S

# *Circular Letter*

VOLUME • VI

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1 MAY 1951



A FAR EAST  
PERIODICAL



OF ARMY  
MEDICAL SERVICES  
INFORMATION

MEDICAL SECTION • GHQ • FAR EAST COMMAND

APO 500

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Medical aidmen of the 1st Cavalry Division immunize troops on the frontlines. Preventive medicine during the Korean conflict has reached a remarkable state of proficiency.



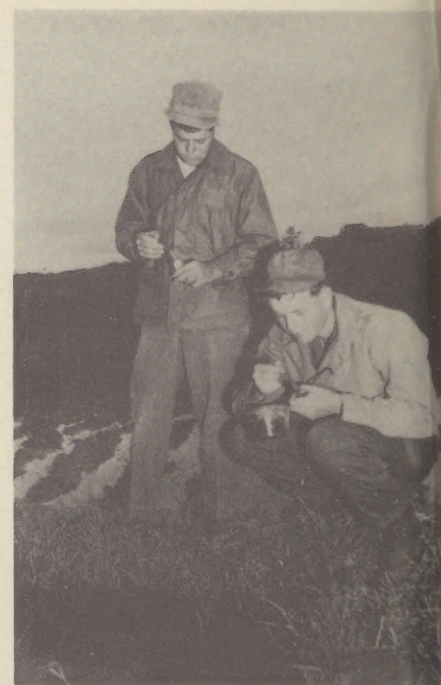
Technicians on Okinawa sample water for germ count survey. Constant vigilance has maintained high sanitary standards.



NK and Chinese Communist POWs are routinely sprayed with DDT in Prisoners of War Enclosure



2nd Division medical aid man administers typhoid "booster" shot to soldiers of his unit.



Mosquito larvae are collected from rice paddy. Lab technicians will identify potential malaria vectors

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THE SURGEON'S

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Volume VI - Number 5  
1 May 1951

General Headquarters  
Far East Command  
Medical Section  
APO 500

## ADMINISTRATIVE

## SUBJECT

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BRIG. GEN. J. S. SIMMONS (Ret.)

### I. MILITARY PREVENTIVE MEDICINE IN KOREA

In the presence of disease hazards almost unparalleled in the annals of American experience, American military medical specialists are successfully carrying out the Armed Forces preventive medicine program in Korea, according to Brig. Gen. James Stevens Simmons (Ret.), Dean of the Harvard School of Public Health.

Although retired since 1946, General Simmons is still senior consultant on preventive medicine to The Surgeon General of the United States Army. He is currently observing health activities in the Far East Command and has made an extensive tour of the Korean battle-front.

"Results show that military preventive medicine has advanced to the point where it is paying rich dividends in the conservation of America's fighting manpower," General Simmons said. "New knowledge developed through recent research has produced new techniques which are currently in use wherever United Nations troops are in Korea - not only to provide the best medical care for the sick and wounded, but to keep well troops well."

In making comparisons, General Simmons said that during the Spanish-American War, the rate for disease deaths among U. S. troops was about 25 per 1,000 per annum; and 13 American soldiers died of disease to every one killed in battle. During World War I the rate was reduced to about 16 and the ratio of disease to battle deaths was only one to one. In World War II the disease death rate for our total Army of about 10,000,000 men was only 0.6 per 1,000 per annum and in the European Theater only one soldier died of disease for every 85 killed in battle.

"Although it is too early to compare the Korean conflict with other wars," General Simmons said, "it is expected that the picture will be as good as, if not better than in the previous conflict."

"Preventive measures are not automatic; they do not apply themselves, nor do they operate by chance alone. Their successful utilization in Korea has resulted from a carefully planned, scientifically organized program of military preventive medicine in the FEC."



General Simmons said that no better measure of the effectiveness of preventive medical practice for United Nations personnel can be found than in the comparison of the occurrence of disease among the enemy.

"Judging by the high incidence of disease among captured Communist troops," he said, "the practice of preventive medicine is not being carried out effectively in their forces. Captured POWs have had an unduly high incidence of diseases, including leprosy, smallpox, typhus, typhoid, tetanus (lockjaw) and other epidemic diseases. This is in sharp contrast to the record of the United Nations troops.

"From the viewpoint of military efficiency, it is obviously more desirable to keep the well soldier well than to provide the expensive and complex facilities required to restore the sick soldier to health. Along with the modern preventive medicine measures, every soldier should keep in mind that 'an ounce of disease prevention is worth a pound of disease cure.'"

Some of the hazards which UN troops in Korea are up against include a wide variety of traditional military plagues - many intestinal diseases, such as the dysenteries and typhoid fever; the mosquito-borne diseases, malaria and Japanese B encephalitis; louse-borne infections, including relapsing fever and epidemic typhus - the ancient scourge of armies in the field. Malignant smallpox is also quite common among the Koreans. The widespread existence of the germ of tetanus is an added potential hazard to the wounded in Korea.

"Fortunately, our troops have been given a high degree of protection against these crippling diseases," General Simmons said. "They are protected against disease bearing insects; they are provided with safe food and water and with proper clothing. These and many other procedures have served to reduce the disease hazards of troops in Korea to a remarkable degree."

General Simmons said the preventive medicine program in the FEC is based on modern advances in public health. It is being applied by the medical services of the U. S. Armed Forces under the guidance of good leadership of highly qualified experts in the fields of preventive medicine and public health.

"Maj. Gen. Edgar Erskine Hume, Surgeon, FEC, holds a public health degree from the Harvard University School of Public Health and has had wide experience in preventive medicine in the Balkans, Italy and other European countries," General Simmons said. "Col. Arthur P. Long, also a graduate of the Harvard Public Health School, is the Preventive Medicine Consultant for FEC. He plans and supervises the preventive medicine program for the entire command. He was awarded the Legion of Merit for outstanding services in this field in World War II and was recently presented with an Oak Leaf Cluster to this medal for meritorious service in this present conflict.

"Under the general supervision and guidance of Colonel Long, there is a small but able group of preventive medicine specialists. Heading this program in Korea is Colonel James E. Gordon, who has done a magnificent job under most difficult conditions.

"The excellent record achieved by the preventive medical staff in the FEC is not being accepted complacently by those responsible for its success. "They are all aware that even greater efforts will be required to meet the increasingly difficult problems which will arise with the coming of warmer weather."

The General added that an intensive program for the control of malaria and other mosquito-borne diseases is being initiated. Steps are being taken to increase the number of preventive medicine specialists and units in the field.

"Ideally, there should be a well-trained preventive medicine specialist assigned to each division or unit of comparable size," General Simmons declared. "The excellent diagnostic and epidemiological laboratory services of the 406th Medical General Laboratory in Japan, headed by Lt. Col. R. L. Hullinghorst, and the mobile laboratory units in Korea, are being augmented. Increased attention and emphasis will be given to the supply of safe water and the continuous training of troops in the necessity of the purification of drinking water.

"There are, of course, still problems to be solved. Hepatitis or jaundice is one of these. Among the others are the many varieties of intestinal infections. Scientific investigations and studies must continue and be increased in their scope to develop applicable methods for the prevention and control of those diseases for which effective preventive measures have not yet been developed.

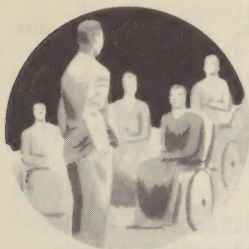
"The men who are fighting for our freedom are the men we are concerned with, and the only grati-



tude the preventive medicine people can offer them is the assurance that they have the backing of the very best that modern scientific medicine and public health can offer, both now and in the future."

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## II. ARMY SECRETARY DECORATES WOUNDED AT TOKYO ARMY HOSPITAL



"I am proud of you", Secretary of the Army Frank Pace, Jr., said while addressing a ward of paraplegics at the Tokyo Army Hospital, "and the American people are proud of you."

Secretary Pace presented the fourth Oak Leaf Cluster to the Purple Heart to one soldier and the Purple Heart Medal to another. Both men had been recently wounded in Korea.

"When I see men like yourselves, something happens to me and I feel small and inadequate," he told the group. "However, I know in my heart that what we are doing is right, and our efforts here will make a difference in the hearts of millions of people in this troubled world. You have won the respect and appreciation of the American people and the peoples of all the free world."

The Tokyo Army Hospital was one of a number of Army installations visited by Secretary Pace during his tour of Japan and Korea in April.

"In Japan itself," he said, "I have had a chance to see many phases of our military operations, including the exceptional treatment our wounded are receiving from our doctors. As always the courage of the wounded and their lack of complaint were most apparent."

As he left the hospital, Secretary Pace congratulated Col. Kenneth A. Brewer, Commanding Officer, on the work being accomplished there. "You are doing a tremendous job," he said. "This is one of the finest Army hospitals I have ever seen."

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## III. INDIAN MEDICAL UNIT PROVES VERSATILITY

Whether their mission is to parachute behind enemy lines, operate a complete mobile surgical hospital for civilian refugees or pull a British soldier's aching tooth, the 331 officers and men of the 60th Indian Ambulance Unit are always ready to tackle the job.



INDIAN MEDICAL TROOPS PRACTICE FIRST AID      MEMBERS OF 60TH INDIAN FIELD AMBULANCE UNIT ON PARADE AT TAEGU

Ten doctors, all veteran paratroopers, jumped with the 187th Airborne Infantry into the Munsan area last March. At the same time, another detachment from the 60th was ministering to the medical needs of hundreds of Korean refugees far from the fighting front at the Taegu City Hospital.

A unit of the Indian Army Medical Corps, the versatile organization has been serving with the UN Forces in Korea since November. The 60th Indian Ambulance Unit, commanded by 33-year old Lt Col A. G. Rangaraj of Madras State, brought all its own equipment with it from its homeland. Even rations are supplied by India.

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## IV. EDUCATIONAL PROGRAM OF THE ARMY NURSE CORPS

Alice A. Lentz, Captain, ANC, 382nd General Hospital

Education is a continuous process; it cannot be confined to one day, one month, or one year. Education is the sum total of everything you think, everything you do, and every bit of information you glean by either formal or informal means.



Our course in History of Nursing has shown us the struggle that was necessary to provide even the bare essentials of the basic nursing program. It was due to the ceaseless and untiring efforts and to the farsightedness of our early nurse leaders that this was accomplished. We constantly and continuously have been and are confronted with the problems of raising the educational and professional standards of nursing.

Every nurse should make it her personal responsibility to further her education. If she does not have a college degree, she should raise the level of her formal education. If she has a college degree, she should broaden her interests in life and keep abreast of the changes and advances in the nursing field and in the related fields. It must be understood that the nurse should be - first and foremost - a good bedside nurse. Any additional general, cultural or professional education should contribute to her efficiency and to her mental, moral, spiritual and physical strength as an individual and as a nurse.

For several years the nurse in civilian life has been aware of the keen competition in the nursing and nursing education fields. This civilian nurse has had to further her education in academic and professional subjects in order to maintain her position and to progress in her field. For the most part this educational program has been the individual's own personal problem and responsibility; she has had to do the work on her own time and provide her own financial backing.

Until recently the Army nurse has not been as aware of this competition as her sister-nurse in civilian life. This may have been due to the fact that she felt she was secure as long as she did an acceptable piece of work and also to the fact that she was subject to change of station. Many have also felt that all provisions for their education should be made without any personal effort whatsoever. If an Army nurse does not demonstrate her desire and her purpose to further her education, should she be given that education by the agency for which she works? Every Army nurse should set a definite goal - to do her part to raise the educational and professional level of herself and of the Army Nurse Corps. It must be remembered that at the present time only Regular Army nurses are eligible for university training. All other courses are available to Regular Army nurses and to Reserve nurses on extended active duty.

Since we are now in the Far East Command, many of the educational facilities in the United States are not available to us. I refer here to the courses in Operating Room Technique and Management, Neuropsychiatric Nursing, Anesthesiology and Administration. However, we cannot assume the attitude that we are without hope or purpose. Many opportunities for academic, cultural and professional advancement are within our reach.

If a nursing education coordinator cannot be assigned as such, it behooves each Chief Nurse:

1. To stimulate and maintain interest in education within her group.
2. To be familiar with methods of establishing and conducting Nursing Staff Education Programs.
3. To be able to give guidance to those nurses who desire to take correspondence courses or courses at local institutions for degree credit.

To elaborate on each of these points:

1. The Chief Nurse should stimulate and maintain interest in education within her group:
  - a. She should be familiar with nursing trends and keep the group informed.
  - b. She should be improving her own education in some area - general, cultural or professional.
  - c. She should be familiar with the required basic courses for a degree in nursing education and know which are available at local institutions, through USAFI, or by correspondence from other universities.
  - d. She should endeavor to make the necessary time arrangements for any nurse interested in attending classes.
2. She should be familiar with methods of establishing and conducting Nursing Staff Education Programs:
  - a. She should have an idea of subjects in which the nurses are interested.
  - b. She should be familiar with recent developments in medicine and nursing and be able to use these as subjects for staff programs.
  - c. She should be familiar with methods of conducting staff education programs:
    1. Lecture
    2. Discussion - conference, clinic, symposium, seminar, panel and workshop.
3. She should be able to give educational guidance to all nurses:



- a. She should work with the Information and Education Officer.
- b. She should guide the nurses in the sequence of courses to be taken; English should be taken first since it will be of value in every other course taken.
- c. She should be familiar with educational facilities of the Army, the requirements and methods of applying.
- d. She should advise the nurses upon their return to the United States to request assignment to a post near an educational center where they may continue study.

Neither an education nor a degree will magically solve all your problems. An education will increase your power of observation; will help you cope with situations as they arise; will give you a psychological and sociological foundation for understanding your fellowman; will give you greater power of oral and written expression; will help you appreciate the cultures of the world; will make you more conscious of the trend of world events; will serve to stimulate your growth as an individual and as a professional person.

In conclusion, may I quote from John Lancaster Spalding's "Things of the Mind": "When we cease to learn, we cease to be interesting. To learn is to teach one's self; for whether we gain intellectual power and knowledge by observation, by reading, or by listening, the result is the outcome of our self-activity."

#### V. RAILROAD MEDICAL EVACUATION VAN

Now in operation in various parts of the combat area is a small fleet of railroad medical evacuation vans. Bus ambulances have been adapted for either rail or road by use of the "Auto-Railer", a commercial product.

The devices were first used in Europe during World War II by a Railway Operating battalion for the purpose of adapting road vehicles for rail operation. This was done in order to have a light vehicle that could be used for railroad inspections and that would be capable of making emergency runs to repair locomotives and cars that had minor failures between stations.

The first Auto-Railers were received in the Far East Command by the 765th Railway Shop Battalion as part of their T/O&E and were first used on a 3/4 ton truck.



Upon request of the Surgeon, Eighth United States Army in Korea, the 3d Transportation Military Railway Service directed the 765th to equip one ambulance bus with rail adapters to be used for experimental purposes. This order was received early in January 1951 and the bus was completed, ready for trial, later in the same month. It was transferred to the 22nd Hospital Train Unit for demonstration purposes. The bus was driven from Pusan to Taegu where it underwent a series of tests conducted by the Medical and Transportation Sections of Eighth Army.

Basically, these demonstrations proved the bus would be satisfactory for emergency evacuation of the sick and wounded from forward installations to rear hospitals. Upon completion of the testing period, five more bus ambulances were ordered adapted for rail operation. These were completed and delivered to the 22nd Hospital Train Unit early in February. Drivers and technicians were assigned to each bus and they were immediately placed in operation.



## VI. AWARDS TO ARMY MEDICAL SERVICE PERSONNEL

The following additional Army Medical Service personnel have been awarded the Distinguished Service Cross, Silver Star, Legion of Merit, Distinguished Flying Cross, Soldier's Medal, Bronze Star Medal, or Commendation Ribbon for exceptional bravery in face of the enemy and meritorious service during the Korean conflict.

### *Distinguished Service Cross*

Martin, Emmette B., Sgt  
Mosier, Billy, Cpl

### *Silver Star*

Abrams, Joseph T., 1st Lt, MSC  
Adams, Dennis L. Jr., Pfc  
Allison, Jack P., Sgt  
Anderson, Clarence, Capt, MC  
Anderson, Charles E., Sgt  
Archambault, Raymond, Sgt  
Auddette, Glenn H., Pfc  
Bindewald, James A., Cpl  
Byars, Joe B., Sgt  
Davis, Howard, Sgt  
Fuller, Wirt C., Pfc  
Garland, Guy C., Sgt  
Grigsby, Richard L., Sgt  
Hallstrom, Richard, Pfc  
Hays, Jack M., 1st Lt, MC  
Hoerner, Gabriel R., Pfc  
Jenkins, Henry L., Sgt  
Kasadda, Milton J., Cpl  
Lafoon, Jesse H., 1st Lt, MSC  
Lewis, Howard C., Pfc  
Lynch, Harold P., Pfc  
McCarthy, Donald R., Sgt  
McClure, Ronnie J., Pfc  
McPherson, Carl E., Sgt  
Medina, Joe A., Sgt  
Miller, George W., Cpl  
Morrison, Arthur F., Capt, MC  
Neal, Frank A., Sgt 1/c  
Peneaux, Thomas F., Pfc  
Penny, Herbert G., Cpl  
Powers, John A., Pfc  
Riley, Edwin L., Cpl  
Scheffler, Charles, Sgt  
Stapleton, James J., Cpl  
Swanson, Charles T., Sgt 1/c  
Walker, Charles A., Pvt  
Williford, Russell, Sgt

### *Legion of Merit*

Binkley, Hubert L., Lt. Col, MC  
Bornstein, Joseph H., Lt Col, MC  
Craig, Allan A., Col, MC  
Goddard, Calvin H., Col, MC  
Hume, Wayne S., Lt Col, MC  
Long, Arthur P., Col, MC  
Moreland, William J., Col, MSC  
Ott, Harold G., Col, DC  
Partin, Everett W., Lt Col, MSC  
Pruitt, Francis W., Col, MC  
Roe, William W., Col, MC  
Selwyn, Robert E., Col, MSC  
Tender, Isaac J., Lt Col, MC  
Wallace, Herbert C., Lt Col, MC

### *Distinguished Flying Cross*

Smith, Burgess A., Capt, MC

### *Soldier's Medal*

Marruffo, Robert P., Cpl  
Moore, Donald R., Pvt  
Robles, Lugardo S., Cpl  
Stubbs, Paul T. Jr., Pfc  
Tubbs, Isaac E., Pfc

### *Bronze Star Medal*

Ahern, Archibald, Maj, MC  
Aigentis, Arthur A., Sgt  
Allison, Jack P., Sgt  
Amaro, Miguel, Cpl  
Anderson, Donald A., Cpl  
Archer, Harvey E., Lt Col, MSC  
Aspinwall, Phillip, Pfc \*  
Asuncion, Juan A., Capt, MC  
Bailey, Richard N., Sgt  
Bakula, Joseph J., M/Sgt  
Baldridge, Thomas W., Cpl \*  
Ball, James A., Maj, MC  
Ballatt, Guy, Jr., Cpl \*  
Barber, Dean C., Pfc  
Barbour, Joseph A., Cpl  
Barrera, Johnny L., Pfc  
Bass, Wilmer C., Sgt  
Baumgardner, Gordon, Pfc  
Beatty, John J., Cpl \*  
Berkebile, Alma J., 1st Lt, ANC  
Bernstein, Robert, Maj, MC \*  
Berry, Cleo E., Sgt \*  
Blake, Francis M., Sgt 1/c  
Blakesley, Lyman, 1st Lt, MSC  
Blood, Gail H., Sgt \*  
Boyd, Raymond A., Sgt  
Braatz, Lavern E., Sgt  
Brackett, Carl W., Sgt  
Brailsford, Lawrence, Cpl  
Brauda, Alton J., Sgt  
Brewer, Otha H., Sgt  
Bricker, Joe F., Pfc \*  
Brinston, Julius L., Sgt \*  
Brooks, James E., Pvt \*  
Brown, Eldon R., Cpl \*  
Brown, Gerald E., Capt, MSC  
Brown, James M., Lt Col, MC  
Brown, Thomas J., Capt, DC  
Cabell, Lawrence W., Cpl  
Caldwell, Clyde, Lt Col, DC  
Carro, Raymond F., Sgt  
Cavanaugh, William, M/Sgt  
Chitwood, Andrew, Pfc  
Christian, George M., Cpl  
Clark, Berkeley, Pfc  
Coburn, Ronald E., Cpl  
Coffman, Harlan, Pfc  
Cofresi, Gilberto, Sgt \*  
Colbert, Paul W., Pfc  
Coleman, Eunice R., Maj, ANC \*  
Colon-Mateo, Victor, Sgt \*  
Confort, Jeanette M., 1st Lt, ANC  
Coon, Roger B., Cpl  
Cooper, Frederick M., Pfc  
Costello, James A., Sgt  
Crabtree, Richard N., Sgt  
Curry, James R., 1st Lt, MSC  
Dalmeida, John R., Sgt  
Dalzell, Donald H., Pfc  
Daniels, Billy R., Pfc  
Davidson, Freddie T., Sgt 1/c  
Davis, Audie N., Sgt  
Davis, James K., Cpl  
Davis, William C., Pvt  
Defler, James R., Sgt \*  
Delson, Ramon Jr., Cpl  
Desrosiers, Paul G., Sgt  
Dice, Wilbur D., Lt Col, MC  
Dodson, Chris T., Sgt 1/c

Donahoo, Fred T., Pfc  
Downing, Leland R., Capt, MSC  
Drowns, Norman S., Capt, MSC \*  
Edenfield, Sammy E., Capt, ANC  
Eglinicki, Henry J., Sgt  
Espindola, Jesus L., Pfc \*  
Evans, John W., Cpl  
Eversole, Robert W., Cpl  
Farrell, James M., Sgt  
Fell, Maxine, Capt, ANC  
Ferry, John C., Cpl  
Fishman, Henry, Pfc  
Flanagan, Ervin, Sgt \*  
Ford, Gene, Pfc  
Forsyth, Donald E., Sgt  
Fort, Daniel W., Cpl  
Foster, Samuel D., Sgt  
Fox, Melvin, Pfc  
Fox, Ralph E., M/Sgt  
Freeman, Jack, Cpl \*  
Fry, Louis C., Sgt 1/c  
Fujii, Arthur J., Sgt \*  
Fuller, Roy T., Sgt  
Funk, Robert L., Pfc  
Galarza, Vincente J., Cpl  
Gallo, Carmen J., Sgt \*  
Gander, Jack, Sgt  
Garland, Luther J. N., Sgt  
Gaskin, Cecil, Cpl  
Gates, Samuel S., Cpl  
Geater, Elmer D., Pfc \*  
Gilbert, Jaw W., Sgt  
Glass, Albert J., Col, MC  
Godin, Richard N., Sgt  
Goins, J. D., M/Sgt  
Gonier, Ernest J., Sgt  
Gordon, Joseph R., Pfc  
Gould, Edward G., Pfc  
Grant, Clarence, Pfc  
Green, Clarence J., Cpl  
Green, Dean L., Pvt \*  
Guck, Richard H., Cpl  
Haegle, Ida L., 1st Lt, ANC  
Hall, David L., Cpl \*  
Hall, Robert R., Cpl \*  
Hamerick, Elmer A., Cpl  
Hammerly, Aloha, 1st Lt, ANC  
Hanlon, James W., Sgt  
Harmon, Jess W., Sgt 1/c  
Harrison, Henry E., Cpl  
Harrison, Stanley A., Pfc \*  
Harvey, Theodore, Cpl  
Hawley, Clifford E., Sgt \*  
Hayes, Robert M., Cpl \*  
Head, William L., Pfc  
Henderson, Dallas, Sgt 1/c  
Hensley, Elmer T., Sgt  
Herron, Orvil L., Pfc  
Hester, George C. Jr., Cpl  
Hicks, Douglas M., Cpl \*  
Higdon, Charles J., Pfc  
Hightower, Hubert J., Cpl \*  
Hill, Verne, Sgt 1/c  
Hipp, Henry F., Cpl  
Hisel, Mark J., Pfc \*  
Jochbaum, Frederick, Pfc  
Holman, Douglas C., Capt, MSC  
Holman, Lyle A., M/Sgt  
Horinek, Martin E., Cpl  
Horton, Elmer F., Cpl  
Howard, Joseph J., Maj, MSC  
Howard, Robert B., Cpl



Hric, Paul F., Pfc  
Hull, Bobbie G., Pfc  
Janicek, Emil H., Sgt \*  
Jimenez, Salvador J., 1st Lt, MSC \*  
Jinkerson, Ralph C., Pfc  
Johnson, Morgan D., Pfc  
Jones, Reva L., Cpl \*  
Jones, Thomas H., Sgt \*  
Juel, Roger A., Maj, MC  
Kamperschruer, John, Pfc \*  
Kanaya, Jimmie, 1st Lt, MSC  
Kaufman, Ralph J., M/Sgt  
Kawata, Kenji K., Pfc  
Kazanowicz, Charles, Cpl  
Kemble, Robert L., Sgt \*  
Kernich, Robert T., Pfc  
Kjar, Grant, Pfc  
Kurokawa, Terumi, Cpl  
Lane, William J., Sgt  
Lankford, Tommy O., Sgt  
Larose, Clifton P., Cpl  
Lawrence, Robert J., Cpl  
Lawynne, Patrick L., Sgt  
Leath, Henry P., Sgt  
LeBlanc, Scuddy, Cpl \*  
Lovolo, Anthony J., Pfc  
Lunsford, Albert J., Cpl  
Lynch, William J., 1st Lt, MSC  
MacKie, Walter H., Capt, MSC  
MacDonald, James W., Capt, MSC  
Marrrs, Ralph E., Pfc  
Marshall, Paul R., M/Sgt  
Matson, Walter M., Pfc  
Mauro, Robert S., Cpl \*  
Max, Sanford L., Capt, MC  
May, Joseph P., Sgt  
May, Marjorie D., 1st Lt, ANC  
Mayes, Theodore A., Sgt  
May, Robert G., Sgt 1/c  
McCollum, John E., Sgt  
McCoy, George W., Col, MC  
McCoy, Wilburn D., Cpl  
McCray, William L., 1st Lt, MSC \*  
McCree, Ernest, Cpl  
McFadden, Joseph, Cpl  
McFarland, Edward, M/Sgt  
McLaughlan, William, Sgt \*  
McLeod, Norman A., Pfc  
McNamara, Arthur B., Sgt  
Merritt, Wilbur J., Sgt \*  
Mickleberry, Stephen, 2nd Lt, MSC  
Mills, Ruth, Capt, ANC  
Miner, Sheril R., Pfc  
Montgomery, Georgie, Cpl  
Mueller, Travis, Capt, MC  
Murray, Ernest J., M/Sgt  
Natishan, Paul, Cpl  
Newsom, Samuel J., Lt Col, MC  
O'Connor, James D., Maj, MSC  
Odom, Samuel C., Pfc \*  
Parks, Robert F., Cpl  
Passero, Anthony, Sgt \*  
Pate, William, Pfc  
Peters, James F., Pfc  
Peterson, Raymond H., Cpl  
Peterson, William H., M/Sgt  
Pleasants, John E., Maj, DC  
Plowman, Floyd C., Lt Col, MSC  
Policino, Leo, Sgt  
Price, David H., Cpl  
Pyle, William K., 1st Lt, MSC  
Quiroz, Rafael Jr., Cpl \*  
Raffety, Frank L., Pfc  
Raines, Guy, Sgt \*  
Ramos, Felix, Pfc  
Randall, Scott W., Pfc  
Ratliff, Tommie, Pfc \*  
Reice, Stephen C., Pfc

Reynolds, Emmett H., Cpl \*  
Reynolds, Kenneth M., Pfc \*  
Richard, Mary Z., 1st Lt, ANC  
Richter, Charles N., Cpl  
Riess, Paul E., M/Sgt \*  
Rigdon, Jonathon M., Col, MC  
Riggins, William T., Cpl  
Riggs, Stanley D., Pfc  
Roberson, Wonsham B., Capt, MSC  
Robinson, Charles A., Sgt  
Rodriguez, Raul, Pfc  
Rogers, Edward C., Sgt 1/c  
Royston, Haskell H., Pfc  
Ryburn, Bobby T., Cpl  
Salvo, Joseph P., Capt, MSC  
Sanders, John L., Cpl \*  
Sapp, Leondrus, Cpl  
Sawyers, Virgil G., Pfc  
Schelthelm, George, Sgt  
Schneider, Nick P., Sgt  
Scott, Herman M., Pfc  
Shafer, Laverne, Sgt  
Sharp, John T., Capt, MC  
Shaw, Harold J. Jr., Cpl  
Shepherd, Robert A., Cpl  
Sherwood, Gary C., Pfc  
Shole, Ralph J., Sgt 1/c \*  
Siems, Florence, Capt, ANC  
Skeehan, Raymond A., Capt, MC  
Smith, Arthur M., 1st Lt, MSC  
Smith, Marcel G., Capt, MC  
Spaeth, Agatha B., 1st Lt, ANC  
Stark, George W., Capt, DC  
Staron, Mary, 1st Lt, ANC  
Stephan, Carl, Capt, MC  
Stephens, Louis J., Sgt  
Strait, Charles A., Pfc  
Sulkowski, Cecelia, Capt, ANC  
Sulpizio, Virginia, 1st Lt, ANC  
Swisher, Billy E., Cpl  
Tafs, William D., Maj, MSC  
Taylor, Boyd L., Pvt  
Taylor, George, Sgt  
Thomas, Joseph W., Maj, MC \*  
Thompson, John E., Pfc  
Thurness, Elizabeth, Capt, ANC  
Tipton, Thomas C., Pfc  
Tobanico, Raymond G., Sgt  
Tropiano, Joseph F., Pfc  
Turner, Abner L. Jr., Cpl \*  
Tuskey, Kenneth J., Sgt \*  
Unger, Melvin V., Pfc \*  
Upton, Willie E., Cpl  
Wagner, Elvin M., Sgt  
Walker, Lonnie G., Pfc  
Wall, James G., Capt, MC  
Ward, Mary, Capt, ANC  
Warner, Vernon B., Pfc \*  
Wasielewski, Theodore, Sgt  
Weddington, Wallace, Sgt  
Wehrenberg, Robert, Sgt \*  
Wenz, Erwin P., Capt, MC  
Wheeler, Edward W., Sgt \*  
White, John F., Cpl \*  
Wier, Lovie D., Pfc  
Wilkowski, Louis V., Sgt \*  
Willard, George, Cpl  
Williams, Michael, Pfc  
Winchell, Wilbur, Pfc  
Wisniewski, Raymond, Pfc \*  
Wood, Joseph, M/Sgt  
Wood, Marvin R., Cpl  
Wyatt, Arlis R., Pfc  
Young, Edgar L., Sgt  
Zalkan, George, Lt Col, MC

(\* BSM with "V" Device)

### Commendation Ribbon

Adams, Maynard E., Cpl  
Alston, Lincoln, Cpl  
Armstrong, Andrew E., Sgt  
Barnum, Orval T., Cpl  
Bell, William H., Cpl  
Bolle, Llewellyn L., Cpl  
Bounds, Wiley B., Cpl  
Brown, William C., Pfc  
Burdette, Joseph Q., Cpl  
Burford, Clifton, Pfc  
Chelf, Bennett L., Pvt  
Cochran, Arthur W., Cpl  
Combest, Jerry C., Cpl  
Davis, Dwight M., Sgt  
Davis, Jesse W., Sgt 1/c  
Davis, Perl, Cpl  
Decker, Oval, Sgt  
Donovan, Howard L., Pfc  
Fanning, William E., Capt, MSC  
Gates, Kenneth L., Sgt 1/c  
Gonzales, Jose B., Cpl  
Greiner, Robert G., Sgt  
Harper, James, Cpl  
Hart, George, Cpl  
Henri, Isaac G., Cpl  
Hensley, Charles C., Cpl  
Horn, Earl J., Cpl  
Isadore, Easton J., Cpl  
Jackson, George W., Sgt  
Jackson, Richard R., Sgt  
James, Norris, Cpl  
Jetland, Robert I., Maj, MSC  
Johnson, Earl M., Pfc  
Johnson, Fred G., Cpl  
Kelly, John L., Jr., Sgt 1/c  
Kline, Allen R., M/Sgt  
Lester, Kenneth D., Cpl  
Maxfield, Wilber, Cpl  
Mayberry, Robert C., Cpl  
McDonald Robert H., Capt, MSC  
Miles, Charlie F. B., Cpl  
Miller, Raymond E., Cpl  
Moore, Taylor III, Cpl  
Munson, Lee N., Sgt  
Newsom, Samuel J., Lt Col, MC  
Nielson, Richard A., Cpl  
O'Connor, Francis J., M/Sgt  
O'Connell, Raymond, Cpl  
Parish, Randall R., Sgt  
Perry, James A., Sgt 1/c  
Perry, Raymond, Pfc  
Persinger, Arthur L., Cpl  
Peterson, Kenneth N., Cpl  
Pike, Leo C. Jr., Sgt 1/c  
Randlett, Robert M., Cpl  
Redix, George, Jr., Sgt  
Schilstra, James, Sgt  
Settle, Thomas E., Cpl  
Shipp, Thomas J., Sgt 1/c  
Singleton, Abnon, Cpl  
Smith, Meddie, Cpl  
Stininger, Calvin, Pfc  
Sullivan, Clifford, Pfc  
Voth, Willie L., Cpl  
Walker, Haskell S., M/Sgt  
White, Robert A., Pfc  
Whitford, John W. Jr., Pfc  
Williams, Johnnie L., Cpl  
Williams, Jerry, Sgt  
Wilson, Ronald L., Pfc  
Witt, Gustave J., M/Sgt





## VII. SALVAGE AND REPLACEMENT OF PYROXYLIN-COATED TENT LINERS

The following extract of DA Circular 24, "Liner, Tent, Surgical Operating Truck and Tent, Sectional Hospital", 30 March 1951, is published for the information of all concerned.

"1. General. - Recent field exercises indicate that liners coated with pyroxylin constitute a fire hazard and should be salvaged and replaced. It is essential that a 100 percent inspection be made of all liners, tent, surgical operating truck, and liners, tent, sectional, hospital in storage at installations and depots (including stock in separate storage and assemblages), and in the hands of troops. All panels of each liner must be inspected and tested since in many instances different panels of the same liner have been found to contain varying types of treatment.

"2. Testing compound. - The following testing compound, to be made available by local purchase, will be used in identifying the pyroxylin treatment:

Solvent formula: Ethyl acetate. . . . . .50 percent by volume.  
Ethyl alcohol (Denatured). . . . . .30 percent by volume.  
Naphtha . . . . . .20 percent by volume.

"3. Method of testing. - Place several drops of the mixed solvent on the surface of the coating. Allow to stand for 1 minute and then touch with the finger the area covered by the solvent. If pyroxylin is in the binder of the coating composition, that area will wipe off very readily because the mixture is a good solvent for the same.

"4. Disposition of liners. - Liners found with pyroxylin coating will be salvaged.

"5. Replacements. - Requisitions will be submitted through channels for replacement of Liners, Tent, Sectional only. Tent, Surgical, Operating, Truck and components, has been reclassified as obsolete."

## VIII. CONSERVATION OF SUTURES

Attention of all FEC Medical Supply Officers is called to Port Medical Supply Information Letter I-41, Office of The Surgeon General, 4 April 1951:

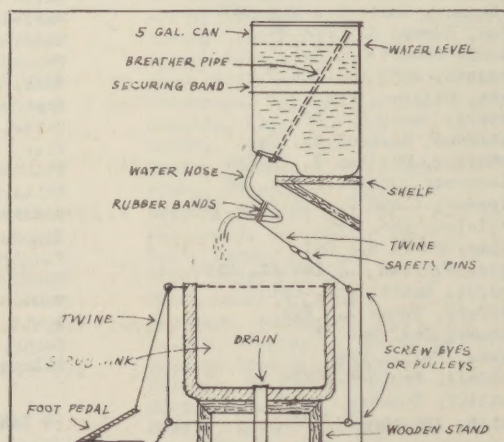
"1. The hospital expansion program for the Armed Services has caused an increase in the consumption of sutures, which is overtaking industry due to the shortage of sheep gut casings.

"2. Industry has pointed out that 2½ times as much material is required for Size 2 sutures as for Size 00; and further, that the tensile strength of the smaller size sutures has been increased to such an extent as to make use of the smaller sizes more practical than in the past.

"3. In order that as many sutures as possible may be obtained from the casings available to industry, all concerned are requested to bring to the attention of operating personnel the importance of conservation through use of the smallest size suture consistent with the need. Unless conservation of sutures is given serious consideration and actually put into immediate practice, nonavailability of all sizes of suture may result."

## IX. FIELD EXPEDIENT FOR SCRUB-SINK WATER SUPPLY

A field expedient for scrub-sink water supply, simply constructed from available odds and ends, has been improvised by Cpl Bobbie L. Crain, Surgical Technician of the 1st Mobile Army Surgical Hospital. Starting with a 5-gallon gasoline can as the water source and a breather pipe from a tent stove assembly, a piece of large rubber tubing was attached to the outlet from the screw cap to serve as a faucet. The shut-off feature on the rubber hose faucet was simply rigged by attaching smaller tubing or rubber bands to the large tube at sites about 6 inches apart. The tension of these bands keeps the tube kinked and stops the flow of water from the inverted can. A string leading from the lower attachment of the bands and around to the front of the scrub sink permits pressure on a foot pedal with resulting pull on the string to straighten the kinked hose and permit flow of





water for scrubbing. The can may be quickly refilled after disconnecting a safety pin link between the string attached to the rubber band kinking device and the string extension to the foot pedal.

#### X. RECENT DEPARTMENT OF THE ARMY PUBLICATIONS

AR 40-508, C-2, 22 Mar 51: Medical Service: Medical Care for Nationals of Foreign Governments in Army Medical Treatment Facilities

AR 40-1025, C-7, 22 Mar 51: Medical Department - Records and Reports of Sick and Wounded

AR 30-331, 5 Apr 51: Food Service - Ice Issues and Sales

AR 40-506, C-2, 5 Apr 51: Medical Service - Persons Eligible to Receive Medical Care at Army Medical Treatment Facilities

SR 50-140-20, 29 Jan 51: Sanitation: Military Assistance for Pest Control in Civilian Communities

SR 750-605-6, 29 Jan 51: Maintenance of Supplies and Equipment - Medical Field Maintenance Shops and Missions

SR 40-530-45, 27 Feb 51: Medical Service - Reports of Patients by Specialized Type of Treatment, (RCS-MED 77)

SR 140-105-6, C-2, 27 Feb 51: ORC - Appointment in Army Medical Service Sections

SR 140-105-6, C-3, 2 Mar 51: ORC - Appointment in Army Medical Service Sections

SR 730-630-1, 6 Mar 51: Oversea Supply - Marking of Medical Assemblages

SR 140-105-9, C-1, 8 Mar 51: ORC - Appointment in Army Medical Service Sections of Individuals Registered under Selective Service Act of 1948, as amended

SR 40-1025-30, 19 Mar 51: Medical Service - Admission and Disposition Report for Oversea Hospitals (RCS-MED 76)

SR 40-1025-90, 22 Mar 51: Medical Service - Remaining Cards

SR 40-940-5, C-1, 26 Mar 51: Medical Service - Communicable Diseases of Animals

SR 41-45-1, 26 Mar 51: Hygiene and Sanitation - Monthly Sanitary Report (RCS MED-3(R1))

SR 40-340-5, 29 Mar 51: Medical Service - Spectacles

SR 725-15-1, 30 Mar 51: Issue of Supplies and Equipment - Army Medical Service Regulated Items

DA CIR 24;AFL 67-42, 30 Mar 51: Liner, Tent, Surgical Operating Truck and Tent, Sectional Hospital (See Sec VII, page 88, this issue)

T/O&E 8-37, C-3, 16 Nov 50: Medical Company, Infantry Regiment, Airborne

T/O&E 8-566, C-2, 2 Feb 51: Station Hospital, 500-Bed, Communications Zone

T/O&E 8-780, 7 Feb 51: Veterinary Field Hospital

T/O&E 8-561, C-1, 8 Feb 51: Station Hospital, 25-Bed, Communications Zone

T/O&E 8-562, C-1, 8 Feb 51: Station Hospital, 50-Bed, Communications Zone

T/O&E 8-563, C-1, 8 Feb 51: Station Hospital, 100-Bed, Communications Zone

T/O&E 8-565, C-2, 8 Feb 51: Station Hospital, 300-Bed, Communications Zone

T/O&E 8-581, C-2, 8 Feb 51: Evacuation Hospital, Semimobile

T/O&E 8-551, C-2, 8 Feb 51: General Hospital, 1,000-Bed, Communications Zone

T/O&E 8-22, C-2, 21 Feb 51: Hqs & Hqs Detachment, Medical Group

T/O&E 8-57, C-2, 21 Feb 51: Medical Holding Company

T/O&E 8-567, C-1, 2 Mar 51: Station Hospital, 750-Bed Communications Zone

T/A 8-4, 30 Jan 51: Training Allowances for Convalescent Centers in Oversea Theaters

T/A 11-101 (8-565), 13 Feb 51: Allowances of Signal Corps Expendable Supplies for Station Hospital, 300-Bed Communications Zone

T/A 11-101 (8-567), 5 Mar 51: Allowances of Signal Corps Expendable Supplies for Station Hospital, 750-Bed, Communications Zone

TB MED 62, 13 Mar 51: Medical X-Ray Protection

TC 7, 26 Mar 51: Convalescent Center, Army



# TECHNICAL

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Erythema Multiforme and Its Variants. . . . .	XIII	94
Emergency Management of Chest Injuries. . . . .	XIV	95
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## XI. THE CLINICAL USE OF FEMORAL PUNCTURE

Major Ralph E. Brown, Jr., MC, Surgical Service, 4th Field Hospital, APO 301



Nearly every physician has experienced the feeling of desperation in attempting to start intra-venous fluids in the treatment of shock, severe burns, and chronic illness when a collapse of the peripheral circulation makes routine vena-puncture an impossibility. Time spent in searching for a vein often assumes great importance when a life is at stake and early preparation of such a patient for surgical treatment is essential. "Cut-downs" are likewise time-consuming and often of little or no value since it is difficult to force large quantities of blood back into the circulation through them. Arterial

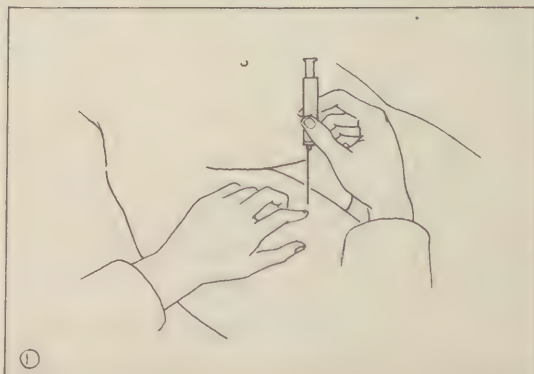
transfusions are quite useful but do not lend to the treatment of large numbers of wounded and require somewhat more elaborate equipment and close supervision.

Femoral vein infusion is a most useful way in which to handle these problems and has so much to offer that it is surprising that it is not used more frequently. It can be used in battalion aid stations, collecting or clearing stations as well and as easily as in a hospital ward or operating room. It requires no equipment that is not readily available to all echelons of medical care. This type of infusion is most easy to perform and its technique can be taught to nurses and enlisted technicians.

It has been used extensively by the author for over 15 months and in many different types of cases. In personal use and in teaching its technique to others, several hundred punctures have been observed both in the field and in the hospital. The same needle has been left in place as long as a week with no evidence of thrombosis of the vein. This is especially useful in the early management of extensive burn cases during which numerous blood studies are made in order to follow and treat chemical imbalances. Blood samples are very easy to obtain with the needle in place and the necessity of painful and frequent vena-punctures is prevented. No complications have been observed with the exception of an occasional hematoma. Thrombosis and thrombophlebitis of the vein have been searched for repeatedly and have not been found, although it is conceivable that in aged patients who have sclerotic vessels other complications may arise. Accidental puncture of the artery may occur and presents no cause for concern. It is easily recognized by two distinguishing features. The first is the color of the blood and the other is the pressure with which the blood is forced back into the syringe. The difference in the color of the blood in the femoral artery and vein is quite striking, even in patients who are in shock. When this occurs the needle is withdrawn and introduced further medially into the vein. Firm pressure with the finger over the artery for a few minutes will obviate bleeding through the arterial wall into the soft tissues.

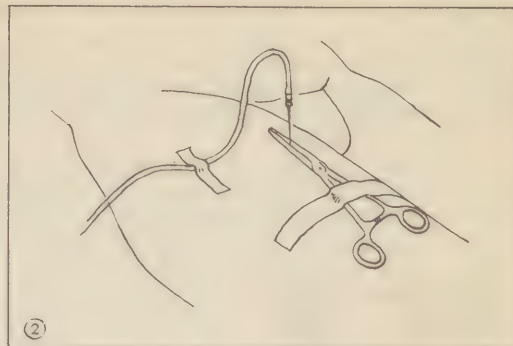
### TECHNIQUE:

A large needle (15 to 18 gauge), a 2.00 cc syringe, a straight hemostat and adhesive plaster is all that is needed in the way of equipment. Occasionally it is helpful to infiltrate the area with a small amount of 1% procaine, but this is the exception. With the needle in place on the syringe and held in the right hand, the groin of choice is swabbed with an alcohol sponge in the left hand. The tips of the first two fingers (Fig. 1) are now used to palpate the femoral arterial pulsation approximately one and one-half to two inches below the inguinal ligament. Remembering the relation of the vein to the artery in this area, the needle is introduced





with the right hand just medial to the palpable pulsation and exactly perpendicular to the long axis of the vein. Suddenly the blood will appear in the syringe. A straight hemostat will be taken in the right hand and the blades closed about the needle. The hemostat is now taped to the thigh to maintain the proper position of the needle, (Fig. 2). A final withdrawal on the barrel of the syringe will help one determine that the needle has not been dislodged. The syringe is now removed and the glass adaptor from the intra-venous fluid of choice inserted into the end of the needle. In the very seriously wounded patient in profound shock 500 cc of whole blood may be given in less than ten minutes by attaching the bulb from a blood pressure cuff to an ordinary sterile glass adaptor and rubber tube and inserting it into a needle in the air vent of the transfusion bottle. (The adaptor, rubber tube and needles are kept sterile for this purpose.)\*



It is to be emphasized that the introduction of the needle into the vein should be perpendicular to the long axis of the vein -- i.e., at right angles. This is quite an important point in the technique as described.

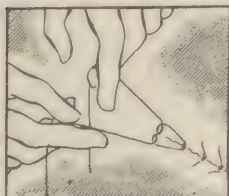
#### SUMMARY:

The value of femoral vein puncture is presented to bring attention to its extreme usefulness in treating seriously wounded patients in shock, with severe burns, and long-standing chronic illnesses in which the peripheral circulation leaves much to be desired as an avenue of fluid therapy. Its technique is described. Indications and complications are briefly discussed. It is hoped that its usefulness will be recognized by others and that it may be as enthusiastically adopted as an adjunct in the treatment of urgent surgical problems as the author has found it.

(\* When using the bulb from a blood pressure cuff to produce positive pressure and hasten the rate of flow, caution must be exercised to prevent air embolism. Should the bottle be emptied of its fluid contents, the air under pressure may enter the vein rapidly. This must be prevented by constant vigilance.)

#### XII. SECONDARY CLOSURE OF WAR WOUNDS

Lt. Colonel David Fisher, MC, Chief, Surgical Service, 8th Station Hospital



Successful secondary closure of war wounds is dependent on many factors, including the following: (1) Thorough and adequate debridement to include a removal of foreign bodies; (2) Proper preparation of the wound; (3) Closure without tension; (4) The use of fine suture material and gentle handling of tissues, and (5) Adequate drainage. I propose to discuss each of these factors and, in addition, special situations in wounds of the face and back.

(1) **DEBRIDEMENT:** Patients that arrive at hospitals in Japan for definitive treatment have for the most part been debrided at a previous installation. This debridement may or may not have been thorough, dependent on many factors other than poor surgical judgment. No criticism should ever be directed at a previous installation or surgeon unless one is in possession of all facts concerning the entire evacuation situation as well as the local picture. The fact remains, however, that some wounds do arrive inadequately debrided and this must be corrected prior to secondary closure, although both may well be done at the same sitting. Adequate debridement includes removal of all necrotic tissue; evacuation of bits of clothing, dirt, gravel, etc., that may be ground into the wound, drainage of abscesses, and removal of metallic foreign bodies. One is concerned only with those metallic foreign bodies within the wound tract. Those that are distant and require removal for definite reasons must be approached through a separate incision, as an elective procedure and not concomitant with the debridement and secondary closure.

During World War II, several groups advocated no inspection of the wound until arrival in the operating room. I cannot ascribe to that principle. It is necessary to see all wounds upon entry into hospital in order to make an intelligent evaluation as to future procedure based on the appearance of the wound.

Upon completion of the debridement, one must make a clinical decision as to the advisability of closing the wound at the time, or preparing it several days. Wounds differ so greatly, it is difficult to lay down any criteria to cover the many situations that present themselves. In



very broad terms, however, the following principles apply. Debridement and closure may be attempted at one sitting under the following conditions:

- a. Minimum to moderate amount of wound drainage without frank abscesses.
- b. Presence of fairly firm red granulations (as opposed to greyish boggy granulations) or clean muscle tissue.
- c. Ability to close the wound with relatively little or no undermining. If it is necessary to undermine flaps beyond two or three cm, it is usually wise to prepare the wound prior to closure.
- d. The presence of exposed viable tendon or nerve, or uninfected bone should cause one to consider closure as early as possible.
- e. The presence of infected bone in the base of the wound should tend to delay early closure unless very adequate drainage is possible. In wounds of this type, the area adjacent to the infected bone may be closed early and the area over the infected bone at a later date.

(2) PREPARATION: Those wounds that require preparation for closure are best treated by the wet pressure dressing method. The solution that one uses to keep the surface and dressing wet is relatively unimportant. It may be saline, boric acid, or any fluid that is sterile and non-irritating. In some instances, where the blood supply to the wound is jeopardized, a layer of penicillin or another antibiotic may be useful, but in the usual case, local antibiotics are not essential.

Two other items are considered essential in wound preparation. They are (1) pressure; (2) the application of one layer of fine mesh gauze immediately next to the wound. Pressure is necessary to keep granulations down and to prevent their becoming boggy and exuberant. The fine mesh gauze which has 44 threads to the square inch (ordinary roller bandage) when placed next to the wound prevents the granulations from growing through the dressing and being ripped off with each change. In the process of wound healing, the tiny capillaries that proliferate around the fibrin bed are extremely delicate; these will not grow through fine mesh gauze but will grow through the ordinary 4 x 4 gauze dressing. A layer of wet fine mesh gauze is laid smoothly against the wound. Several layers of wet 4 x 4s or 4 x 8s are next applied. Waste or wet abdominal pads comprise the third layer and then firm even pressure is applied to this bulky dressing by the use of the 5 yard gauze roll which is 5 inches in width and makes an excellent container for the pressure dressing. The whole is then wrapped with roller bandage. Oil silk or parchment is contra-indicated as this macerates the skin from excess fluid due to lack of evaporation.

If the wound is severely infected, Dakins tubes are inserted at the base of the dressing to allow continuous wetting of the wound. If the wound is moderately infected, solution may be added in 12 hours by pouring it into the base of the dressing without the use of Dakins tubes. The wound is dressed and inspected daily. In the usual wound, bacteriological studies are not ordinarily required to determine antibiotic sensitivity. Penicillin alone or the penicillin sulfadiazine combination will usually provide a sufficiently broad spectrum to obtain either bacteriocidal or bacteriostatic action. If there is any doubt as to the predominant organism, or if the wound does not do well after two or three days of wet dressing, bacteriological studies with antibiotic sensitivity tests are in order. The usual wound should be ready for secondary closure after two to four days of the above described procedures.

(3) CLOSURE WITHOUT TENSION: The basic surgical principle of closing any wound without tension is applicable in secondary closures. When suture material is used to pull tissue together so that tension is present rather than simple approximation, breakdowns are almost certain to follow. Necrosis from tight tension sutures is a frequent cause of failure in closures. During the four to six day period wounds can usually be closed by trimming of skin edges without dissection of the wound base. Beyond this period, it is usually necessary to completely excise the wound down to fascia making certain that granulation tissue is completely dissected. Wide undermining of flaps will then allow the wound to close without tension. This preferred procedure is referred to in the literature as "excision en masse" or "block excision". Fascia should never be completely closed if there is any question as to underlying infection. Muscle tissue should be approximated with loose holding sutures.

Those wounds that do not lend themselves to closure without tension should be grafted rather than "take a chance". The vast majority of unsuccessful secondary closures are attended with sufficient skin loss due to necrosis that split grafting is necessary for subsequent closure. If sufficient skin loss exists it is better to resort to grafting initially, thus preventing additional trauma to the patient, multiple procedures and loss of time. A goodly percentage of wounds lend themselves ideally to partial closure without tension and closure of remainder of the wound by split skin grafting.



The use of the relaxing incision is likewise a helpful procedure in relieving tension on suture lines. By means of the relaxing incision, one actually produces a double pedicle flap for closure of the original wound. Subsequently, the raw area produced by the flap shift is grafted. In dealing with flaps, one must remember that the length of the flap should rarely be more than two times the width. Long wounds require relaxing incision at a considerable distance from the wound edge in order to allow for sufficient width of the flap. Failure to observe this principle will result in loss of parts of the flap, especially in the mid-portion where the blood supply is the poorest. It is just as necessary to drain the wound beneath the flap as in simple secondary closure without flap shift.

(4) USE OF FINE SUTURES: The type of suture material used is a definite factor in successful wound closure since wound healing may be retarded by the use of heavy suture materials with their attendant maximum foreign body reaction. One should be able to close the great majority of war wounds using No. 120 or 80 cotton as buried sutures and 3-0 black silk for the skin. In those instances where it is desirable to avoid buried sutures, .012 or .009 in. stainless steel wire should be used, not as tension sutures, but as through and through sutures. Because of their non-irritating qualities to tissue, steel sutures may remain in situ for 10 to 12 days. Gentle handling of tissues is another aid to wound healing. The use of the skin hook instead of the tooth forceps in handling the edges of a wound is a most desirable technique. This will prevent small necrotic areas in the suture line. Finally, the use of plaster splints for immobilization purposes places the part at rest and prevents stress and strain in the suture line.

(5) DRAINAGE: All combat wounds (with the exception of face wounds) measuring over two or three cm should be drained when secondarily closed. The presence of infection in all these wounds demands a drainage pathway that will allow wound secretions to come to the outside rather than be contained within a closed area. Drainage can usually be accomplished with a piece of rubber tissue laid in the wound bed beneath the suture line and presenting at the dependent portion of the wound. (NOTE: A small stab wound away from the suture line frequently is useful.) The drain may be removed in 48 hours in the majority of instances, in 72 hours in the remainder. In the absence of complications, it is rarely necessary to allow the drain to remain longer than three days.

Wounds of the face require special consideration since the original debridement and closure is important not only for cosmetic purposes, but to future success in reconstructive procedures. The blood supply of the face is extremely abundant so that tissue loss due to interference with vascular channels is not nearly as extensive as in other parts of the body. Therefore, debridement of necrotic tissue should be exceedingly conservative. Excise only tissue which is definitely necrotic. If in doubt, do not excise. Buried sutures of 120 cotton should be used to approximate muscle and the subcutaneous layer. For skin closure, 6-0 ophthalmic silk may be used. A large pressure dressing is then applied to reduce to a minimum, postoperative edema and the oozing of blood. Face wounds frequently may be closed without drainage, but if in doubt, drain. With adequate buried layer of sutures, removal of the skin sutures should be started in 48 hours and completed in 96 hours. The wound is supported by a strip of fine mesh gauze saturated with collodion and the pressure dressing continued only if indicated.

Wounds of the back frequently break down because of the failure of immobilization. The back muscles are used in many motions of the body and it usually is necessary to include underlying muscle in the suture in order to remove the tension from the suture line. The use of stainless steel wire from skin through muscle to skin on the opposite side is a very useful procedure. The post-operative pressure dressing likewise assists in immobilization. (NOTE: Splints and plaster casts used judiciously are of great value.)

In summary, the following principles should be followed in the secondary closures of war wounds:

1. Thorough debridement prior to closure is essential.
2. Closure within the 4 to 6 day period is ideal, but the appearance of the wound rather than the length of time is the governing factor.
3. Wounds that require preparation for surgery should be treated by the wet pressure dressing method.
4. The principle of closure without tension is of paramount importance. This may be accomplished by any one of several methods, but excision en masse is preferred.
5. Adequate drainage of most wounds is essential.
6. Gentle handling of tissues and the use of fine suture material are definite aids in wound healing.
7. Wounds of the face and back require special consideration.



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### XIII. ERYTHEMA MULTIFORME AND ITS VARIANTS

Colonel Francis W. Pruitt, MC, Medical Consultant, GHQ, FEC

The medical staffs of hospitals in the Far East Command repeatedly encounter syndromes involving the eyes, mouth, genitalia, and skin, with or without systemic manifestations. According to the degree of involvement of the parts just mentioned, these are cataloged as Stevens-Johnson syndrome, Behcet's disease, or Reiter's disease. These have been described by the authors bearing the name of the disease and other writers have added additional physical findings in subsequent reports. An excellent article has been published recently<sup>1</sup> discussing these syndromes as manifestations of erythema multiforme. The following table is reproduced from this paper.

COMPARATIVE STUDY OF SYMPTOMS IN ERYTHEMA MULTIFORME AND ITS VARIANTS

	Erythema Multi- forme	Stevens-Johnson Diseases	Behcet's Disease	Ectodermosis Erosiva Plurio- ificialis	Reiter's Disease
EYE LESIONS	Conjunctivitis	Conjunctivitis	Conjunctivitis		
	Conjunctivitis, purulent			Conjunctivitis, purulent	Conjunctivitis, purulent
	Keratitis	Keratitis	Keratitis	Keratitis	Keratitis
	Swelling of lids				
	Vesicular con- junctivitis			Vesicular con- junctivitis	
	Vasculariza- tion of cornea				
	Episcleritis				Episcleritis
	Conjunctivitis membranous				
	Symblepharon		Symblepharon		
	Corneal opaci- ties				Corneal opaci- ties
	Panophthal- mitis	Panophthal- mitis			
		Kerato-con- junctivitis sicca			
			Hypopyoniritis		
			Retinitis		
			Uveitis		
			Phlyctenulae		
			Neuroretinitis hemorrhagica		
			Iridocyclitis		
			Choroiditis		
			Iritis		Iritis
					Corneal ulcers
ORAL MUCOUS MEMBRANE LESIONS	Vesicles and bullae	Vesicles and bullae		Vesicles and bullae	
	Erosions				
	Annular lesions				
	Superficial ulcers	Ulcers in pharynx	Ulcers on lips, tongue, buc- cal mucosa	Ulcers in pharynx	Superficial crusted ul- cers
	Iris lesions				
GENITAL LESIONS (Male)	Pseudomembrane formation	Pseudomembrane formation			Canker sores in mouth
	Nonspecific urethritis	Nonspecific urethritis		Nonspecific urethritis	Nonspecific urethritis
					Balanitis cir- cumpinata
	Balanitis	Balanitis			Inflammation of urethral mea- tus



GENITAL LESIONS (Female)	Inflammation of urethral meatus				
			Herpes-like vesicles		
	Vaginal ulcers	Vaginal ulcers	Deep vaginal ulcers	Vaginal ulcers	
JOINT LESIONS	Arthralgia		Arthralgia		
	Arthritis		Arthritis	Arthritis, transient	Arthritis, rheumatoid
SKIN LESIONS	Macules	Lesions of erythema multiforme	Lesions or erythema multiforme	Macules	Lesions of erythema multiforme
	Papules			Papules	
	Vesicles and bullae	Vesicles and bullae		Vesicles and bullae	Keratosi s blennorrhagica
	Erythema nodosum		Erythema nodosum		Erythema nodosum
			Furuncles		Pustules
			Seborrheic dermatitis		
			Acne-like eruption		
			Hyper-reactivity		Urticaria

While many authors feel that Reiter's disease should be classified as a form of rheumatoid arthritis, there are others who feel that it is a variant of erythema multiforme. Another point in support of the first contention is the fact that keratosi s blennorrhagica sometimes seen in Reiter's is more commonly a manifestation of the rheumatoid group. One other differentiation point might be well to keep in mind: Reiter's and Stevens-Johnson's syndromes usually run an afebrile course while ectodermosis erosiva pluriorificialis is more likely to be accompanied by fever ranging up to 104° to 105° F. Robinson and his group report favorable response with the use of aureomycin therapeutically. They recommend two or three grams as an initial dose, followed by one-half gram every three hours until the symptoms have subsided.

<sup>1</sup>Robinson, H. M.: The Ocular-Mucous Membrane Syndrome, The Medical Clinics of North America; 35:315-331, March 1951



#### XIV. EMERGENCY MANAGEMENT OF CHEST INJURIES

Major A. R. Valle, MC, Chief, Thoracic Surgery Section, Tokyo Army Hospital

The well-established principle of restoring normal physiology as soon as possible is of paramount importance in the care of thoracic injuries.

The fundamental treatment of shock is not changed because of the presence of a thoracic injury; however, the nature of the lesion makes certain modifications necessary. The administration of blood is governed, as in shock due to other causes, by clinical evaluation of the patient and frequent observations of the pulse and blood pressure. Oxygen should be administered as soon as

possible, the method of administration being decided by facilities available in forward areas.

In general, the ideal position of the patient with a chest injury is that in which the trunk is elevated at an angle of 45 degrees. The position of the patient should be changed every hour, alternating between the back and the affected side; the patient should not be allowed to rest on his uninjured side. The patient should be encouraged to cough at least every hour; cough is most beneficial when the patient is able to sit up in bed. Penicillin, 300,000 units, should be given intramuscularly twice daily; the use of other chemotherapeutic agents is guided by the nature of the infecting organism and the state of the wound.

Sucking wounds of the chest: As soon as possible after it is sustained, a sucking wound of the chest must be closed with vaseline gauze and an air-tight dressing. After the patient has been evacuated from the forward areas, the wound should be debrided and closed in layers without drainage. Water seal closed drainage of the pleural cavity is seldom necessary in uncomplicated sucking wounds, but may be necessary if extensive pulmonary parenchymal damage with a bronchopleural fistula is present. In this instance the danger of a tension pneumothorax is usually obvious; if



M.A. was wounded on 10 February 1951. On 2 March a right thoracotomy was done at a MASH, as shown in picture #1. He was admitted to the Tokyo Army Hospital, 7 March and dependent drainage was established 8 March as shown in picture #2. On 5 April, decortication was done at the Tokyo Army Hospital and the patient is doing well.



A tube placed in this manner cannot possibly drain the chest adequately.



Open thoracotomy using large tube at most dependent portion of chest is effective.

there is doubt, it is advisable to aspirate air from the chest at frequent intervals. If the lung fails to expand, and the intrapleural pressure rises again after aspiration, closed drainage should be carried out. Introduction of the catheter is best done under general anesthesia. A large No. 30 French catheter is introduced into the pleural cavity through a stab wound in the seventh or eighth costal interspace in the mid-axillary line. The position of the tube is maintained by a silk suture passing around the catheter and anchored to the adjacent skin.

A water seal drainage may be constructed from a 1000 cc narrow neck flask (of the type in which intravenous fluids are commonly supplied) fitted with a rubber stopper with two holes. The flask is one-third filled with saline, and through the holes in the stopper two glass tubes are introduced. The shorter of these tubes is placed well above the surface of the fluid, and provides an avenue of escape to the outside for air above the surface of the fluid. The longer of these tubes is introduced to a depth of one centimeter beneath the surface of the fluid, and the tube leading from the pleural cavity is connected to the end of this glass tube. The bottle should never be raised to the level of the thorax unless the catheter is clamped. The tube should be clamped whenever the patient is transported.

**Hemothorax:** Aspiration of blood from the pleural cavity should be carried out as soon as a diagnosis of hemothorax is made; early expansion of the lung is thus achieved, and infection or organization of the clot is avoided. Aspiration should be carried out daily until no blood is obtainable; as much blood as possible should be removed at each aspiration. Blood loss by this route must be replaced by transfusion, as indicated by studies of the patient's hemoglobin. At the completion of each aspiration, 300,000 units of crystalline penicillin and one gram of streptomycin, both dissolved in 2-3 cc. of isotonic saline, should be introduced into the pleural cavity. Thoracentesis for hemothorax is carried out with a 15-17 gauge needle, connected through a three-way stopcock to a 30 cc. syringe. The needle may be introduced through the eighth or ninth costal interspace, posteriorly or laterally. Use of the three-way stopcock obviates aspiration of air while the syringe is being emptied.

Closed thoracotomy with intercostal catheter drainage attached to underwater seal is not recommended for treatment of simple hemothorax. This form of treatment results in a higher incidence



of empyema. In addition, should thoracentesis be necessary after removal of the intercostal tube, it is more difficult because of fluid loculations resulting from adhesions produced by the presence of the tube. Furthermore, in hemothorax closed drainage usually loses its value within 24 to 36 hours because of occlusion of the tube by fibrin and clots, and by pleural adhesions about the intrathoracic portion of the tube. Experience has shown that two or three thoracenteses require less time than closed thoracotomy with insertion of an intercostal tube so that the time factor is favored by thoracentesis.

**Severe intrathoracic hemorrhage:** Patients admitted with chest wounds who are in shock, and whose x-rays reveal massive hemothorax with displacement of the mediastinum to the opposite side, should be suspected of having severe intrathoracic bleeding. Immediate thoracentesis should be performed with aspiration of as much blood as possible, and simultaneous blood transfusion should be instituted.

The patient's blood pressure, pulse and respirations should be recorded frequently since reaccumulation of blood in the chest with mediastinal shift is characterized by rise in pulse and respirations and fall in blood pressure. If two or three thoracenteses and administration of more than 1000 or 1500 cc. of blood are required within a 12-hour period without stabilization of the patient's condition, exploratory thoracotomy for control of bleeding probably will be required. This should be performed under intratracheal general anesthesia through a posterolateral incision with resection of one rib to provide adequate exposure.

After control of bleeding, an intercostal drainage tube, size 30 or 32 French, should be placed in the 7th or 8th interspace in the mid-axillary line before the chest is closed. This tube should be attached to an underwater drainage set immediately post-operatively.

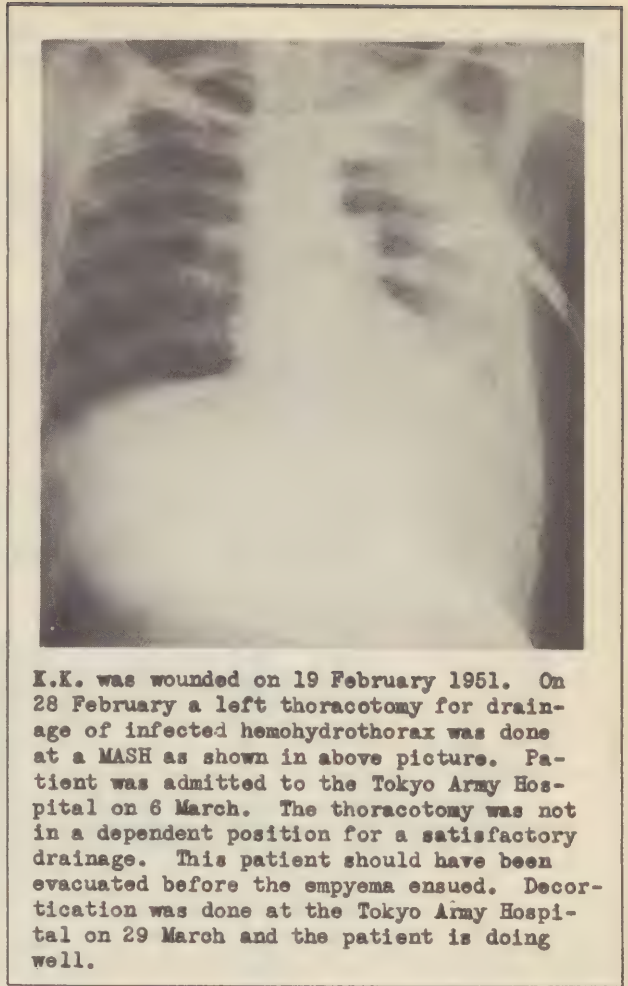
**Large defects of the chest wall:** In general these injuries are associated with a severe degree of shock requiring immediate and sustained therapy. The principle of treatment is that of debridement with thorough removal of bone fragments, after which the adjacent tissues are mobilized and approximated. However, this extensive treatment is best deferred until the patient can be transported to a general hospital. Interim therapy should be directed toward providing as airtight a temporary dressing as possible.

**Simple rib fractures:** Simple fractures of one or two ribs without displacement generally require no specific treatment. More extensive fractures, or fractures with displacement and paradoxical respiration require that the affected hemothorax be strapped. Three inch adhesive bandage is placed from the midline anteriorly to the midline posteriorly; several inches of chest wall above and below the sites of fracture should be included.

**Subcutaneous emphysema:** Subcutaneous emphysema of itself requires no specific therapy. Its importance lies in its indication that an underlying pneumothorax may be present; the latter should be treated by aspiration or drainage as outlined above.

**Sedation:** Depression of the cough reflex to a degree insufficient to accomplish removal of bronchial secretions must be avoided in prescribing sedatives and analgesics. Demerol, in a dose of 50-100 mgm. depending on the size and condition of the patient, is considered suitable. The dose should not be repeated more often than every 6 hours. The use of opium derivatives in chest injuries is discouraged.

**Early evacuation:** Treatment of thoracic injuries in the field is directed toward the prevention



K.K. was wounded on 19 February 1951. On 28 February a left thoracotomy for drainage of infected hemohydrothorax was done at a MASH as shown in above picture. Patient was admitted to the Tokyo Army Hospital on 6 March. The thoracotomy was not in a dependent position for a satisfactory drainage. This patient should have been evacuated before the empyema ensued. Decoration was done at the Tokyo Army Hospital on 29 March and the patient is doing well.



of mortality and reduction of morbidity by supplying the patient with adequate pulmonary exchange, and by controlling shock. Definite treatment should be initiated as soon as possible, and this aim will be secured by evacuation of the patient to the Chest Section of a Fixed Hospital as soon as he may be safely transported.

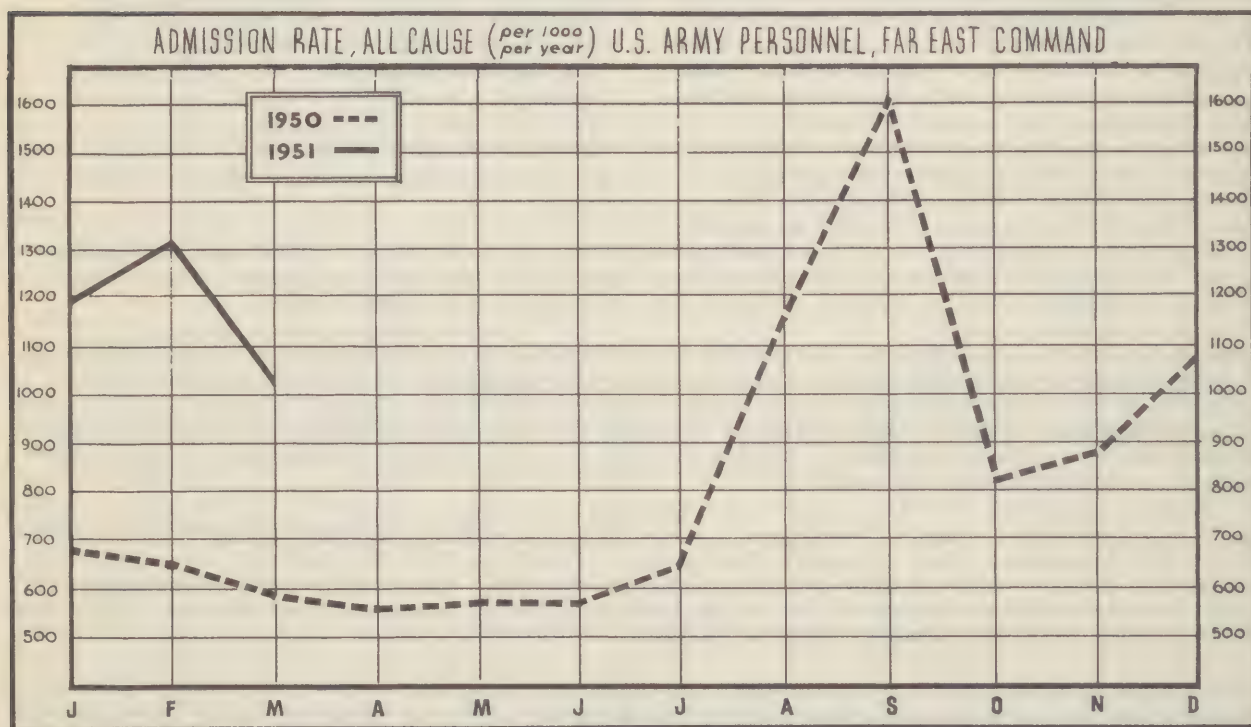
#### XV. HISTOPATHOLOGY STUDY SETS

The Pathology Department, 406th Medical General Laboratory, APO 500, has available for loan the following study sets. These have been obtained from various sources, are accompanied by lists of diagnoses and in some instances by discussions of the cases and clinical histories.

1. Neuropathology. . . . .	50 slides	7. Muscle Tumors. . . . .	21 slides
2. Brain Tumor . . . . .	49 "	8. Skin Pathology . . . . .	50 "
3. Surgical Pathology. . . . .	99 "	9. Pediatrics . . . . .	25 "
4. Surgical Pathology. . . . .	25 "	10. Hematology . . . . .	24 "
5. Orthopedic Pathology. . . . .	50 "	11. Ophthalmic Pathology . . . . .	25 "
6. Genito-Urinary Pathology. . . . .	25 "		

These sets may be borrowed for two to four week periods depending on the size of the set and the number of requests received. A written request to the Pathology Department will be required and the officer signing the request will be held responsible for the proper safeguarding, packing and return of the sets.

## HEALTH OF ARMY TROOPS, FEC



Admission rates per 1000 troops per annum, Army personnel, for the 5-week period ending 30 Mar 51 were as follows:

	<u>FEC</u>	<u>JAPAN</u>	<u>KOREA</u>	<u>MARBO</u>	<u>PHILCOM (AF)</u>	<u>RYCOM</u>
All Causes	1014	630	1188	383	394	604
Diseases	729	591	797	326	317	548
Injuries	153	39	201	57	77	57
Battle Casualties	132	0	189	0	0	0
Psychiatric	32	24	37	8.8	0	4.0



Common Respiratory Diseases and Flu	122	106	133	88	69	46
Primary Atypical Pneumonia	5.1	4.3	5.5	0	0	6.1
Common Diarrhea	13	2.7	17	0	0	0
Bacillary Dysentery	.56	.15	.70	0	0	1.0
Amebic Dysentery	.53	.15	.48	0	0	4.0
Malaria, new	2.2	1.9	2.4	0	8.6	0
Infectious Hepatitis	24	9.2	31	4.4	0	11
Mycotic Dermatoses	.83	.89	.81	0	8.6	0
Rheumatic Fever	.83	.30	1.1	0	0	0
Venereal Diseases	130	206	100	4.4	69	215

#### ALL CAUSES ADMISSION RATE:

In March, Army personnel of the FEC were admitted to hospital, quarters and dispensary for all causes at a rate of 1014 per 1000 strength per year. This is a considerable decrease from the February rate which was 1313 and is accounted for by decreases in the rates of all three of the components (diseases, nonbattle injuries and battle casualties). The FEC's lower rate reflects directly experience in Korea during the month.

A decrease in disease admissions was reported during the month resulting in a rate of 729 as against 850 for February. During March, the only reportable diseases in which a notable decrease occurred were common respiratory diseases, influenza and pneumonia. Of the major commands, Korea's decrease from a rate of 970

in February to 797 for this month depicts the greatest change. During March, the disease admission rate in Japan decreased from 636 in February to 591, minor increases were reported by PHILCOM (AF) and RYCOM, while MARBO's rate remained static.

For the second consecutive month, the nonbattle injury rate for the FEC decreased. In comparison, the rate was 153 per 1000 strength per year in March as against 221 for the previous month. The decrease in the FEC rate is primarily attributed to the marked decrease in cold injuries in Korea. RYCOM experienced an increase in this rate from 45 in February to 57 in March, while all other commands reported decreases. Korea's rate dropped from 306 to 201.

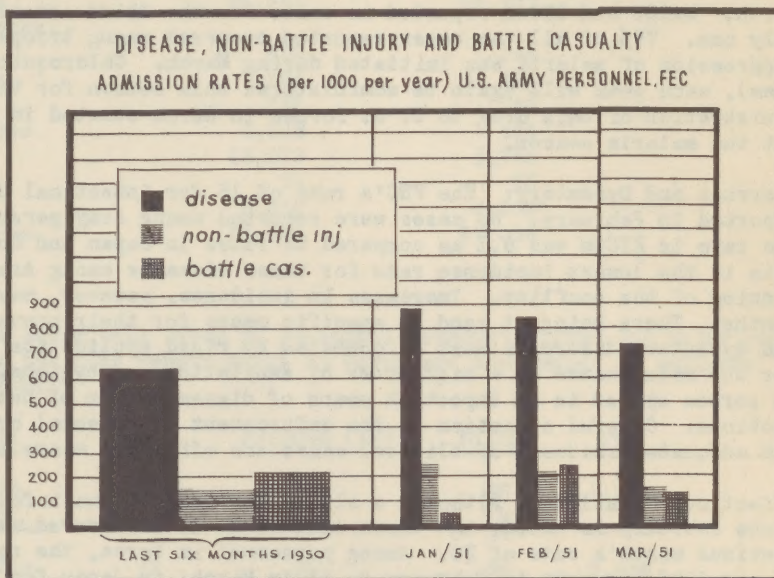
The battle casualty admission rate of 132 for March is a considerable decrease from the February experience of 243. In Korea, the rates for the same periods were 189 and 363 per 1000 per year respectively.

#### DAILY NON-EFFECTIVE RATE:

For the first three months of 1951 the non-effective rate has remained static. The two principal factors affecting this rate have been a fairly constant all causes admission rate, and a more realistic 120-day evacuation policy for patients to the ZI. The FEC rate for March was 49 per 1000 strength per year as against 51 in February and 48 in January. No significant change in this rate was experienced by any of the major commands during the month.

#### DISEASES:

**Common Respiratory Diseases and Influenza:** For the second consecutive month, the incidence rate for common respiratory diseases and influenza decreased. The March rate for the FEC was 122 as compared to 155 for February. This rate is considered commensurate with the season of the year. MARBO, PHILCOM (AF) and RYCOM had rates of 88, 69 and 46 respectively for the month, and although these rates represent minor increases over the previous month, they are nevertheless considered favorable. Among Army personnel in Korea, the rate of these diseases decreased from 183 for the preceding month to 133, while in Japan the rate decreased from 117 to 106.





**Psychiatric:** Admissions for psychiatric conditions during March denote no significant change from the previous month. The FEC's rate of 32 for March compares favorably with previous military experience under similar conditions in other theaters of war. Of interest is the fact that in Japan, where living conditions are reasonably comfortable, and there is no environmental stress of combat, the psychiatric rate for the month was 24 per 1000 strength per year. In Korea, where the troops are exposed to uncomfortable living conditions, plus the severe stress of combat, the rate for the same period was 37. This indicates a relatively low incidence of psychiatric casualties under combat conditions. The psychiatric rate is usually a measure of morale and motivation. Perhaps the relatively low rate for these conditions in Korea may also be due to the anticipation of a combat rotation policy which was publicized during March.

**Malaria:** The rate of new cases of malaria in the FEC increased from .9 in February to 2.2 in March. MARBO and RYCOM reported no cases for the third consecutive month, while PHILCOM (AF) had only one. 76% of all the cases reported occurred among troops in Korea. The program for the drug suppression of malaria was initiated during March. Chloroquine diphosphate, one tablet, (half gram), each week will again be administered this season for the suppression of malaria. The administration of this drug to U. S. forces in Korea started in mid-April and will continue throughout the malaria season.

**Diarrhea and Dysentery:** The FEC's rate of 15 for intestinal diseases infections is the same as reported in February. No cases were reported among Army personnel in MARBO and PHILCOM (AF). The rate in RYCOM was 6.1 as compared to rates in Japan and Korea of 3.1 and 21 respectively. This is the lowest incidence rate for these diseases among Army personnel in Korea since the beginning of the conflict. Increases in incidence, however, may be expected during the coming months. There being at hand no specific means for their prevention, the occurrence of diarrheal and dysentery disorders must be combated by rigid application of unit and individual procedures for the maintenance of a high order of sanitation and hygiene. It is to be recalled that person to person spread is an important means of dissemination of bacillary dysentery and related infections. Careful attention to the enforcement of personal hygienic measures and early diagnosis and adequate treatment of clinical cases are effective means of control.

**Infectious Hepatitis:** Although a slight decrease in the infectious hepatitis rate for the FEC since February is noted, the March rate of 24 is considered very high and is surpassed only by the previous month's rate of 26. Among personnel in Korea, the rate for this disease decreased from 35 per 1000 strength in February to 31 in March; in Japan for the same period, the rate decreased slightly from 9.6 to 9.2. The rate for RYCOM troops is the highest so far for that command, and is an increase from 7.7 in February to 11 in March. One case was reported by MARBO and none by PHILCOM (AF).

**Venereal Diseases:** The March venereal diseases rate of 130 is an increase over the February rate which was 114. Coexistent with the FEC's increased rate was an increase by all major commands. Japan experienced the greatest increase, rising from 173 to 206. RYCOM's rate of 215, as in the past, was the highest rate for an individual major command. Korea, with a rate of 100, is the highest so far reported by that command since June of 1950. Of significance is the fact that although the venereal diseases rate is high, the average number of venereal disease non-effectives per day throughout the FEC was only .06 per 1000 strength. In comparison, reported venereal disease cases constituted 12.8% of all admissions, yet only .12% of the total non-effectives.

**Smallpox:** Six cases of smallpox, one resulting in death, were reported among U. S. Army personnel during the month, all occurring in Korea. Ten cases were reported among all other UN personnel, not including South Koreans. Of these ten cases, two were U. S. Navy, two U. S. Merchant Seamen (one death), one Philippine, three Turks (three deaths), one Canadian, and one British. As has been true of previously reported cases, failures in accomplishment of successful vaccination have been the direct cause of the smallpox occurring during March. These failures continue to emphasize the need for proper attention to the successful execution of the vaccination procedure, its accurate interpretation and proper recording.

**Deaths:** During the five weeks covered in the March report, 168 deaths were reported by medical treatment facilities as having occurred among Army personnel of the command. Of these, 106 occurred among battle casualties, 41 among nonbattle injury cases, and 21 resulted from diseases.

#### DENTAL ACTIVITIES:

An index to the current volume of dental treatment being rendered in the FEC is given in the following extracts from the consolidated REPORT OF DENTAL SERVICE for the month of March 1951. The number of "Cases Diagnosed" and "Operations Performed" exceed those of any month during the past four-year period. The number of dental officers assigned likewise has attained an all-time high



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for the same period.

<u>FAR EAST COMMAND</u>	<u>MARCH 1951</u>	<u>MARCH 1950</u>
Admissions, routine	21,918	9,478
Admissions, emergency	8,203	2,165
TOTAL. . . . .	30,121	11,643
Sittings	65,393	38,823
Examinations	29,246	12,634
Permanent fillings	32,451	20,777
Prosthetic appliances:		
Full dentures	592	235
Partial dentures	1,265	713
All other types	232	182
Repairs, all types	1,018	474
Teeth extracted	13,078	5,763
Fractures reduced	91	28
Prophylaxis	5,282	4,395
All other operations	33,630	27,035

## EVACUATION:

Tabulated below are the number of patients (all types of personnel) evacuated from the major commands to the zone of interior during the five report weeks in March and the number of patients awaiting evacuation as of 30 March 1951:

	<u>JAPAN</u>	<u>MARBO</u>	<u>PHILCOM (AF)</u>	<u>RYCOM</u>	<u>FEC</u>
By Air	2,320	10	13	48	2,391
By Water	51	2	3	18	74
Total	2,371*	12	16	66	2,465
Patients Awaiting Evacuation	77	0	0	24	101

(\* 1,799 patients originated from Korea)

## HOSPITALIZATION:

The bed status as of 30 March 1951 was as follows: (These data cover all patients, Army, Air Force and others.)

	<u>Bed Capacity</u>		<u>Operating</u>		<u>% Normal Bed</u>	<u>% of Operating</u>
	<u>Normal</u>	<u>Mobilization</u>	<u>Beds</u>	<u>Beds Occupd.</u>	<u>Capacity Occupd.</u>	<u>Beds Occupd.</u>
JAPAN	10,550	11,310	10,550	9,960	94	94
KOREA	2,960		2,960	1,923	65	65
MARBO	200	200	200	28	14	14
PHILCOM(AF)	250	250	167	118	47	71
RYCOM	250	300	250	251	100	100
FEC	14,210	12,060	14,127	12,280	86	87

In Korea 12,362 operating beds are established for POW of which 10,562 are occupied.

On the cover

First Lieutenant Giuliot Barber, M.C. (right), and Lieutenant (j.g.) Howard Mermelstein, USNR, examine an eleven year-old Korean child ill with arthritis at the CAC Childrens' Clinic in Pusan, Korea.

(All photographs are from U.S. Army Signal Corps unless otherwise stated.)

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The Chief Surgeon extends an invitation to all personnel of the Army Medical Services to prepare and forward, with view to publication, articles of professional or administrative nature. It is assumed that editorial privilege is granted. Copy should reach the Medical Section, General Headquarters, Far East Command, not later than the 10th of the month preceding the issue in which publication is desired.

Lt. John J. Griffin, Editor

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